

FILED OCT 17 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35850

BIRTH NO. _____		REG. DIST. NO. 324		PRIMARY REG. DIST. NO. 3072		Registrar's No. 203	
1. PLACE OF DEATH a. COUNTY Saline				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY Saline			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Marshall		c. LENGTH OF STAY (in this place) 5 days		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Slater		0971	
d. FULL NAME OF HOSPITAL OR INSTITUTION Fitzgibbons Hospital				d. STREET ADDRESS (If rural, give location) 236 E. Parker 0			
3. NAME OF DECEASED (Type or Print) a. (First) Lucas		b. (Middle)		c. (Last) Jackson		4. DATE OF DEATH (Month) (Day) (Year) Oct. 12-50	
5. SEX male 0		6. COLOR OR RACE white		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married		8. DATE OF BIRTH Jan. 28-1883	
9. AGE (In years last birthday) 67		10. UNDER 1 YEAR 8		11. UNDER 10 HRS. 14		12. CITIZEN OF WHAT COUNTRY? U S	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Common labor		11. BIRTHPLACE (State or foreign country) Howard County, Mo.		12. CITIZEN OF WHAT COUNTRY? U S	
13a. FATHER'S NAME Jacob Jackson		13b. MOTHER'S MAIDEN NAME Cristine		14. NAME OF HUSBAND OR WIFE Louise Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Louise Jackson, Slater, Mo			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Essential hypertension DUE TO (c) Paralysis of swallowing Reflex and R. Pt. Hemiplegia II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH 4 days Years 33 1/2 4 day	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? - YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 2, 1950, to Oct. 12, 1950, that I last saw the deceased alive on 10-12-50, and that death occurred at 4:15 p. m., from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. A. McJannet, M.D.				23b. ADDRESS Slater, Mo		23c. DATE SIGNED 10/13/50	
24a. BURIAL, CREMATION, REMOVAL (Specify) burial		24b. DATE Oct. 14-50		24c. NAME OF CEMETERY OR CREMATORY City Cemetery, Glasgow, Mo.		24d. LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. 04-13		REGISTRAR'S SIGNATURE Sidney T. Gray		385 Hill Brothers		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Slater, Mo	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED 10/16/57
DISTRICT HEALTH OFFICE No. 3
District File Number _____
Date Filed 10-16-57

10-16-57

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student _____
Student Embalmer

Signed

A. C. Hill

Licensed Embalmer No. 3090

P. O. Address Stater Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.